EXPLANATION OF BRACKETS

Plans A through E Policy and Certificate
(Appendix Exhibits A and V for Plan A and F and W for Plans B – E)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
b) Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
g) Some areas of variability are determined by the delivery system (i.e., indemnity, PPO or POS)
h) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.
i) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO or POS plans, explicit guidance is set forth in item 27 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 30 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets for the HMO plan, which appears later in this document, for guidance on the variable text that appears in the HMO form that would be issued in conjunction with the indemnity form to produce the Dual Contract POS Plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
3. Although the schedule pages specify the plan letter in the upper right corner this identification is intended solely to identify which plan letter the page illustrates. Carriers need not specify the plan letter on the schedule pages of plans being issued.
4. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
5. If a Carrier elects to provide for a family deductible and family maximum out of pocket allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The appropriate multiple of the individual deductible and maximum out of pocket must be included. The BENEFIT PROVISION of the HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **Note**: ALL plans issued by a Carrier MUST include the same option.
6. There are alternate PPO and POS schedule pages that allow carriers to use separate or common deductible and maximum out of pocket provisions. These features may be used, at the option of the carrier. There are corresponding provisions in the benefit provisions.
7. The list of services and supplies for which pre-approval is required includes two new items, included in brackets: specified therapies and prescription drugs. The benefit provisions for these services and supplies also includes text in brackets concerning pre-approval. Carriers that elect to require pre-approval for these services and supplies must include them on the list on the schedule page in addition to using the pre-approval text in the benefit provision.
8. The Reinstatement provision may be included or omitted, at the option of the carrier. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
9. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy - Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
10. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
11. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

12. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the policy form.
13. The definition of Referral should be included in POS plans that require referrals.
14. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
15. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
16. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. The text may address a date certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
17. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
18. The text describing provider compensation in the PPO and POS sections contains a number of bracketed words and phrases. Include the words and phases that describe the arrangement carrier has with network providers.
19. The continuation of care text must be included in all plans that use networks.
20. The treatment of hemophilia provision includes variable text that would only be included in PPO and POS plans.
21. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
22. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
23. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy. **NOTE:** A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.
24. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, the text must conform to the text of the standard form, except that the

penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty.

25. The Specialty Case Management provision may be omitted. Carriers may administratively provide for such provisions. If included in the policy and certificate, the text must conform to the text of the standard form.
26. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
27. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:
    a. The policy and certificate documents contain "SAMPLE" schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:21-3(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier may use. ($5, $10, $15, $20, $30, $40 or $50)
    b. Include the specific page of text describing either the PPO or the POS mechanism, with specification of the name of the network or provider organization.
28. Carriers that intend to use the standard indemnity forms as the non-network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Only Plans C and D may be used to provide the non-network benefits. Plans C and D must be issued as pure indemnity plans. That is, they may **not** be plans issued through or in conjunction with a Selective Contracting Arrangement.

Throughout the text, variable text which begins with "DC" appears. **All** of the variable text which is designated as "DC" text **must** be included when indemnity plans C or D are used as the non-network portion of a Dual Contract POS plan. **All** of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

In **addition** to the above items, Carriers must consider the following in connection with the certificate forms:

29. The face page text may be modified to be consistent with a carrier's methods of certificate personalization. The certificate level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
30. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar

titles used to identify the document provided to employees insured under an employer's group plan.

31. Variable schedule data such as deductible, and copayment amounts may be included on the schedule, shown on the face page, sticker or separate schedule.
32. The Payment of Premiums-Grace Period section may be omitted, at the carrier's option.
33. The definition of "You, Your and Yours" may be omitted by carriers that elect to refer to the employee as Employee, rather than use the personal "You". Throughout the text, the words "You," "Your" and "Yours" must be replaced with "Employee" terminology.

Plan HMO Contract and Evidence of Coverage
(Appendix Exhibits G and Y)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does ***not*** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], and [ABC].
b) Some areas of variability are noted with brief explanations within the text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.
e) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
f) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.
g) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

Note: Explicit guidance for the issuance of a Dual Contract POS product is set forth in item 18 below. Carriers that issue a Dual Contract POS product should refer to the above explanations for Plans C and D for guidance on the variable text that appears in the indemnity form that would be issued in conjunction with the HMO form to produce the Dual Contract POS plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract and Evidence of Coverage forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
4. Deductible, coinsurance and maximum out of pocket provisions may be included for network benefits. Applicable text to address the deductible, coinsurance and maximum out of pocket features must be included on the schedule page and in the benefit provisions.
5. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
6. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE:** ALL plans issued by a Carrier must make the optional benefit available in the same manner.
7. The bracketed dispensing limit text contained in the prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
8. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
9. OB/GYNs can be considered Primary Care Physicians.
10. Eligible class references can be removed.
11. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. The text may address a date certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
12. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.

13. Percentage participation requirement as noted in the Participation Requirements and in the Termination of the Policy Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
14. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
15. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
16. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
34. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
17. Carriers that intend to use the standard indemnity forms as the network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Throughout the text, variable text which begins with "DC" appears. *All* of the variable text which is designated as "DC" text *must* be included when the HMO plan is used as the network portion of a Dual Contract POS plan. *All* of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

In addition to the above items, Carriers must consider the following in connection with the evidence of coverage forms:

18. The face page text may be modified to be consistent with a carrier's methods of evidence of coverage personalization. The evidence of coverage level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the document. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
19. The term "evidence of coverage" may be replaced with a similar term used to identify the document provided to employees covered under an employer's group plan.

Plan HMO-POS Contract and Evidence of Coverage
(Appendix Exhibits HH and II)

All text which is enclosed in brackets is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in five ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].
2. Some areas of variability are noted with brief explanations within the text.
3. Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices.
4. Some areas of variability are subject to ranges specified in statute or regulation.
5. Some areas of variability are determined by Carrier elections. [Examples include the use of a care manager, health center, and terms to identify the member, network and non-network benefits.]
6. Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. The forms define and use the terms "Network" or "In-Network" and "Non-Network" or "Out-of-Network." Carriers may replace those terms as they appear in the definitions section, and elsewhere throughout the forms, with alternate terms. (Example: Participating, Non-Participating)
4. The forms define and use the term "Member." Carriers may replace that term as it appears in the definitions section, and elsewhere throughout the forms, with an alternate term. (Examples: Subscriber, Enrollee)
5. The plan may be issued as employee only coverage. Text which addresses dependent coverage, as enclosed in brackets, may be deleted for plans which only make coverage available to employees.
6. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
7. Copayment, deductible, coinsurance and maximum out of pocket amounts may be elected by the Contractholder, subject to the availability specified in regulation. The applicable schedule page and benefit provision text should be included, consistent with whether deductible and coinsurance provision applies to both network and non-network benefits or only to non-network benefits.
8. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees,

Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.

9. Carriers that do not use a "Care Manager" should omit the definition of Care Manager, and omit the term as it appears throughout the text.
10. The definition of "Employer" should identify the name of the employer or specify the location in the Contract and Evidence of Coverage where the employer name is specified.
11. Carriers that do not use "Health Care Centers or Health Centers" should omit the definition of Health Care Centers or Health Centers, and omit the terms as they appear throughout the text.
12. The "Waiting Period" provision may be omitted, or included, at the option of the Contractholder. If included, the duration of the waiting period may not exceed six months, as set forth in N.J.A.C. 11:21-7.9(c). The text may address a date certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
13. The date employee or dependent coverage begins or ends may vary, to accommodate Contractholder, or Carrier administration practices. (Example: Coverage may begin as of the first of the month following any waiting period. Coverage may end immediately, or at the end of the month in which the termination event occurs.)
14. The Selection or Change of a Primary Care Physician or Health Center, and the effective date of the selection or transfer may vary according to Carrier administration, but may not be more restrictive to the member than stated in the form.
15. Carriers that do not have a home care program that satisfies the requirements of the New Jersey "48 hour maternity" statute, (P.L.1995, c.138) should omit the reference to such program in the text of the Inpatient Hospice, Hospital, Rehabilitation Center & Skilled Nursing benefits section of the plan.
16. Carriers may elect to make the optional cancer treatment benefit available as part of the standard plan or as an optional benefit rider. The selected option determines which text the Carrier should include. *Note*: All plans issued by a Carrier must reflect the same Carrier election to either include the optional benefit, or make the benefit available by rider.
17. Carriers may elect to calculate the non-network family deductible as two times the individual deductible, calculated on a per individual basis, or as three times the individual deductible, calculated on an aggregate basis. The Schedule and the Non-Network Benefit provision must reflect the selected calculation. *Note*: All plans issued by a Carrier must reflect the same election.
18. The bracketed dispensing limit text contained in the network prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
19. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
20. Carriers that wish to apply pre-approval requirements to non-network prescription drug coverage should include the variable pre-approval text.
21. The Pre-Existing Conditions exclusion may be omitted.

22. The Utilization Review Features may be omitted in its entirety, or specific sections may be omitted. The penalty for non-compliance may be adjusted to specify a percentage or a dollar penalty. A Carrier that wishes to use alternate text to describe utilization review provisions must submit the text to the Board and the Department of Insurance, pursuant to N.J.A.C. 11:21-4.2.
23. The "Specialty Case Management" provision may be omitted. Carriers may provide for such "case management" administratively. If included in the form, the text must conform to the text of the standard form.
24. The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.
25. Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21-7.6.
26. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
27. The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.
28. The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.

The following explanations apply only to the Evidence of Coverage.

1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.
2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.
3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.

Prescription Drug Rider
(Appendix Exhibit H)

All text which is enclosed in brackets [] is variable.

This rider is designed to be used with both HMO and non-HMO based plans. Policyholder can be changed to read Contractholder, as appropriate. Covered person can be changed to read Member, as appropriate.

Some areas of variability are self-explanatory. Examples include: [Carrier] and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the copayment text.

The rider can be used to provide a card only benefit, a mail only benefit, a card/mail benefit. It can be used to require pre-approval for certain drugs. It can also be used to specify different levels of benefits for preferred v. non-preferred drugs.

Employer Application
(Appendix Exhibit N)

1. Contractholder or Planholder and Contract or Plan, as appropriate.
2. The terms Policyholder and Policy may be replaced with terms insurance and insured may be replaced with coverage and covered, as appropriate.
3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.
4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer, including optional benefit riders. For example, if a Carrier does not offer HMO plans, such text may be deleted.
5. Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.
6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.
7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21.7.3(e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.
8. If a carrier elects to allow applications to be submitted electronically, the signature lines on the application may be omitted. However, New Jersey's Insurance Code does not specifically address the use of electronic mediums for the application process. It is the carrier's responsibility to comply with all existing New Jersey statutes, regulations and pertinent case law dealing with general contract law or electronic signatures to determine acceptability of any electronic application process. The carrier is cautioned, however, that the use of such mediums may result in the

waiving of or limitations in the Carrier's right to contest coverage or limit benefits for pre-existing conditions. The existence of variable material on the standard application form should not be construed as acceptability of the electronic process.